Thank you for choosing to participate in the Alabama Medicaid Program. The Alabama Medicaid Agency and EDS appreciate your interest in the Medicaid Program, and welcome the opportunity to work with you to provide health care services to Alabama Medicaid recipients.

About the Application Packet

The application packet contains the following:

Basic Application Material

(To be completed by all providers)
Alabama Medicaid Provider Type/Specialty Identification Form
Alabama Medicaid Provider Enrollment Application
Alabama Medicaid Provider Agreement

Additional Enrollment Forms

(To be reviewed by all providers and completed as applicable)
Corporate Board of Directors Resolution
W-9 Taxpayer Identification Number Request
Medicaid Audit Information
Electronic Funds Transfer Authorization Agreement
Electronic Explanation of Payment (EOP) Agreement
EPSDT Agreement
Statement of Compliance (Two Copies)
Physiological Laboratory Certification

Reference Materials

(Helpful information that can assist you in completing the enrollment application)
Check List of Required Forms
Frequently Asked Questions (FAQs)
Frequently Used Terms
Contact List
Alabama Medicaid Participation Requirements
Table of County Codes (in-state and bordering states)

How to Complete the Application

1. *Identify your provider type and specialty on the Alabama Medicaid Provider Type and Specialty Identification form.*
2. *Review the Alabama Medicaid Participation Requirements in the Reference Materials section to ensure you meet the minimum enrollment requirements to participate in the Alabama Medicaid program.*
3. *Complete the Alabama Medicaid Provider Enrollment Application.* ***Please type or print legibly using black ink only.***
4. *Read, complete, and sign the Alabama Medicaid Agency Provider Agreement form.* ***Signatures on Section VI – Signature Page, Provider Agreement and Statement of Compliance Forms must be original signatures.***
5. *Review Section III, Required Attachments, of your enrollment application and include any applicable attachments.*
6. *Review the forms in the Additional Enrollment Forms section to determine which apply to you. In this section, all providers must complete at a minimum, the W-9 and EFT Agreement forms. Other forms may be required, depending on the provider's circumstance. Read the purpose of each form to determine whether you should complete the form and return it with the application.*
7. *Review the Required Forms Check List located in the Reference Materials section to ensure you have completed your application correctly and have included all required attachments.*
8. *Make a copy of the application for your files. Send the original application to:*

EDS Provider Enrollment	***301 Technacenter Drive***	***Montgomery, AL 36117***
	OR	
EDS Provider Enrollment	***Post Office Box 241685***	***Montgomery, AL 36124***

Alabama Medicaid Provider Enrollment

Basic Application Materials

Alabama Medicaid Provider Type/Specialty Identification Form
Alabama Medicaid Provider Enrollment Application
Alabama Medicaid Provider Agreement

ALABAMA MEDICAID PROVIDER TYPE AND SPECIALTY IDENTIFICATION FORM

Please circle the appropriate provider type (circle only one) and specialty codes (circle up to five) to ensure proper enrollment. Specialty EQ is used to designate those provider types covered only for EPSDT referred services and Qualified Medicare Beneficiaries. For assistance in choosing the appropriate provider type, please refer to Alabama Medicaid Participation Requirements.

PROVIDER TYPE	SPECIALTY
28 AMBULATORY SURGICAL CTR	A4 AMBULATORY SURGICAL CENTER L2 LITHOTRIPSY
20 AUDIOLOGY/HEARING SVCS	64 AUDIOLOGY
24 CHILDREN'S SPECIALTY CLINICS	E3 EPSDT SCREENING (Must submit CLIA certification. Must complete EPSDT Agreement.) SC CHILDREN'S REHAB SERVICES SD SPARKS REHAB CENTER (Required if working for Sparks) SH HEMOPHILIA (CRS) V6 ORTHODONTIA (CRS) SR RADIOLOGY CLINICS (CRS)
18 CHIROPRACTOR	35 CHIROPRACTOR EQ QMB/EPSDT
92 ANESTHESIOLOGY	N7 ANESTHESIOLOGY ASSISTANT C3 CRNA
08 DENTIST	V2 GENERAL DENTISTRY
79 DENTIST / ORAL SURGEON	SE ORAL & MAXILLOFACIAL SURGERY
91 DURABLE MEDICAL EQUIPMENT	V4 DURABLE MEDICAL EQUIPMENT/OXYGEN
49 FEDERALLY QUALIFIED HEALTH CENTER	N3 CERTIFIED REG. NURSE PRACTITIONER F2 FEDERALLY QUALIFIED HEALTH CENTER E3 EPSDT SCREENING (Must submit CLIA certification. Must complete EPSDT Agreement.) N2 NURSE MIDWIFE N6 PHYSICIAN'S ASSISTANT V2 GENERAL DENTISTRY X4 OPTOMETRY
66 HEARING AIDS	H1 HEARING AID DEALER
14 HOME HEALTH	H3 HOME HEALTH P1 PERSONAL CARE
47 HOSPICE	H6 HOSPICE
05 HOSPITAL 11 SWING BED HOSPITAL (Skilled Nursing Beds)	WC EXTENDED CARE HOSPITAL W6 GENERAL HOSPITAL W2 INPATIENT PSYCHIATRIC HOSPITAL Over 65 W3 INPATIENT PSYCHIATRIC HOSPITAL Under 21 L2 LITHOTRIPSY M7 MAMMOGRAPHY (Must provide certification) W8 ORGAN TRANSPLANTS S5 SWING BED HOSITALS
09 INDEPENDENT LABORATORY	L3 DEPT OF PUBLIC HEALTH LAB 69 INDEPENDENT LAB
58 INDEPENDENT NURSE PRACTITIONER	E3 EPSDT SCREENING (Must submit CLIA certification. Must complete EPSDT Agreement.) 08 FAMILY PRACTICE N1 NEONATOLOGY N3 NURSE PRACTITIONER (Required Specialty) 37 PEDIATRICS (Independent Nurse Practitioners must select N3 as well as either 08, N1 or 37 specialty code.)
10 INDEPENDENT RADIOLOGY	M7 MAMMOGRAPHY (Must provide certification) 36 NUCLEAR MEDICINE 66 PHYSIOLOGICAL LAB (INDEP. DIAG. TEST. FAC) 63 PORTABLE X-RAY EQUIPMENT 30 RADIOLOGY

PROVIDER TYPE	SPECIALTY
12 INTERMEDIATE CARE FACILITY	W4 INTERMEDIATE CARE FACILITY
41 MEDICARE CROSSOVERS ONLY	M4 MEDICARE/MEDICAID CROSSOVER ONLY
90 NON PROVIDER	NM NON MEDICAID PROVIDER
22 OPTICIAN/OPTOMETRIST 23 OPTICAL DISPENSING CONTRACTOR	X3 OPTICIAN X4 OPTOMETRIST X2 OPTICAL DISPENSING CONTRACTOR
99 OTHER	E3 EPSDT SCREENING (Must submit CLIA certification. Must complete EPSDT Agreement.) N2 NURSE MIDWIFE ZZ OTHER P9 PREVENTIVE HEALTH EDUCATION
07 PHARMACY	PA GOVERNMENTAL PB INSTITUTIONAL P2 RETAIL PHARMACY
01 PHYSICIAN 30 PHYSICIAN (COUNTY HEALTH DEPT.) 24 PHYSICIAN (CHILDREN'S SPECIALTY CLINICS) 29 PHYSICIAN (RHC) 49 PHYSICIAN (FQHC)	03 ALLERGY/IMMUNOLOGY 05 ANESTHESIOLOGY S1 CARDIAC SURGERY 06 CARDIOVASCULAR DISEASE C9 COCHLEAR IMPLANT TEAM S2 COLON AND RECTAL SURGERY 07 DERMATOLOGY XA EENT E1 EMERGENCY MEDICINE E2 ENDOCRINOLOGY E3 EPSDT SCREENING (Must submit CLIA certification. Must complete EPSDT Agreement.) 08 FAMILY PRACTICE 10 GASTROENTEROLOGY V2 GENERAL DENTISTRY 01 GENERAL PRACTICE 02 GENERAL SURGERY 38 GERIATRICS 21 HAND SURGERY H2 HEMATOLOGY 55 INFECTIOUS DISEASES 11 INTERNAL MEDICINE M7 MAMMOGRAPHY N1 NEONATOLOGY 39 NEPHROLOGY 14 NEUROLOGICAL SURGERY 13 NEUROLOGY 36 NUCLEAR MEDICINE 40 NUTRITION 16 OBSTETRICS/GYNECOLOGY XI ONCOLOGY 18 OPHTHALMOLOGY SE ORAL AND MAXILLOFACIAL SURGERY X6 ORTHOPEDIC 20 ORTHOPEDIC SURGERY X9 OTORHINOLARYNGOLOGY 22 PATHOLOGY 37 PEDIATRICS P3 PHYSICAL MEDICINE 24 PLASTIC, RECONSTRUCTIVE, COSMETIC SURGERY 28 PROCTOLOGY 26 PSYCHIATRY 29 PULMONARY DISEASE 30 RADIOLOGY R4 RHEUMATOLOGY 33 THORACIC SURGERY 34 UROLOGY S4 VASCULAR SURGERY

PROVIDER TYPE	SPECIALTY
06 PHYSICIAN EMPLOYED PRACTITIONER	E3 EPSDT SCREENING (Must submit CLIA certification. Must complete EPSDT Agreement.) N3 PHYS. EMPLOYED CERT REG. NURSE PRACTITIONER N6 PHYS. EMPLOYED PHYSICIAN'S ASSISTANT
17 PODIATRIST	48 PODIATRY EQ QMB/EPSDT (Required Specialty)
38 PRIVATE DUTY NURSING	P6 PRIVATE DUTY NURSING To participate in the Technology Assisted (TA) Waiver for Adults program, a TA Waiver Addendum must be completed and submitted.
19 PSYCHOLOGIST	62 PSYCHOLOGY EQ QMB/EPSDT (Required Specialty)
26 REHABILITATION CENTER	E3 EPSDT SCREENING (Must submit CLIA certification. Must complete EPSDT Agreement.) M4 QMB ONLY R1 REHABILITATION HOSPITAL
34 RENAL DIALYSIS	H5 HEMODIALYSIS 39 NEPHROLOGY
29 RURAL HEALTH (INDEPENDENT)	R8 FREE STANDING RURAL HEALTH CLINIC E3 EPSDT SCREENING (Must submit CLIA certification. Must complete EPSDT Agreement.) N2 NURSE MIDWIFE V2 GENERAL DENTISTRY
29 RURAL HEALTH (PROVIDER BASED)	R2 PROVIDER BASED RURAL HEALTH CLINIC E3 EPSDT SCREENING (Must submit CLIA certification. Must complete EPSDT Agreement.) N2 NURSE MIDWIFE V2 GENERAL DENTISTRY
11 SKILLED NURSING FACILITY	S5 NURSING FACILITY
15 TRANSPORTATION	A1 EMERGENCY (Ground ambulance) TB FIXED WING TA HELICOPTER
21 THERAPIST	T6 OCCUPATIONAL THERAPY T1 PHYSICAL THERAPY EQ QMB/EPSDT (Required Specialty) T2 SPEECH THERAPY (Hospital Based Therapists are not eligible to enroll.)

One provider type per application must be circled, along with at least one relating specialty. The specialties related to a specific provider type are blocked in the area across from the provider type. Example: Provider Type 38 is Private Duty Nursing, the only specialty that coincides with this provider type is P6, which is Private Duty Nursing.

ALABAMA MEDICAID PROVIDER ENROLLMENT APPLICATION

***All Information must be completed in the space below each block or marked "N/A."**
*Original signature is required. Copies or stamped signatures are not acceptable.

ALL APPLICANTS MUST FILL OUT ACCORDINGLY

Please Check Applicable Boxes

APPLICANT ENROLLING AS: (Please check ONE)
- ☐ Individual
- ☐ Group/Payee
- ☐ Facility/Organization

ACTION REQUEST: (Please check ONE)
- ☐ Initial Enrollment
- ☐ Re-certification
- ☐ Change of Ownership
- ☐ Additional Locations

Please Check Applicable Boxes

APPLICATION TYPE: (Please check ONE)

The item selected in this area, relates to the performing provider name indicated on the line below.

- ☐ Individual Practitioner (0)
- ☐ Sole Proprietorship (1)
- ☐ Government-owned (2)
- ☐ Business Corporation, for profit (3)
- ☐ Business Corporation, non-profit (4)
- ☐ Private, for profit (5)
- ☐ Private, non-profit (6)
- ☐ Partnership (7)
- ☐ Trust (8)
- ☐ Chain (9)

SECTION 1 – GENERAL INFORMATION

Note: Please refer to Frequently Used Terms in the Reference Materials for definitions

Group/Company or Last Name First Initial Title/Degree (as appears on license)

(This is the name of the provider who performs the service. If enrolling a group/payee or facility, indicate that name here.)

Physical Address –(PROVIDER PHYSICAL STREET ADDRESS – See County Codes in Reference Materials Section)
Number Street Room/Suite City State ZIP County Code

Social Security Number (For individual enrollment only) Professional License No. **(C)** Issue Date

Resident License Number: Limited License Number:

Medicare Intermediary/Carrier Medicare Number Medicare Certification Date **(C)**

Employer's Tax ID Number Legal Name According To The IRS

(Tax information submitted in this section must match that which is indicated on the W-9 tax form in this application.)

Driver's License Number & Issuer: Driver's License Expiration Date

DEA Number: **(C)** CLIA Number: **(C)** Date of Birth:

Business Phone Toll-free Phone Fax Number

Contact Name Contact's Phone Contact's Fax Number

Payee Name

(This is the name of the provider who receives the payment. If this information differs from the provider who performs the services, a group application will be required. Please contact, Provider Enrollment regarding exceptions at 1-888-223-3630 or (334) 215-0111.)

Payee Address – (PROVIDER'S PAYEE/MAILING ADDRESS)
Number Street Room/Suite City State ZIP County Code

Payee Phone Toll-free Phone Fax Number

Nine-digit Alabama Medicaid payee number if applying to join an existing group:

SECTION 1 – GENERAL INFORMATION – Cont.

Do you plan on using a billing agent to submit your Medicaid claims? ☐ Yes ☐ No
If yes, provide the following information about the billing agent:
Billing agent name:_____

Address: _____

Tax ID No.: _____

Contact person name: _____

Telephone No.: (_____) _____–_____

List all Alabama Medicaid provider numbers under which you have billed in the past 12 months:
(attach additional sheets if necessary)

_____

_____

_____

Answer These Questions if Applicable

Facilities Only:	Yes	No	N/A
Is this a freestanding (independent) facility?	☐	☐	☐
Is this a hospital-based facility?	☐	☐	☐
Is this an ESRD facility?	☐	☐	☐

Pharmacies Only:	Yes	No	N/A
Is this a retail pharmacy?	☐	☐	☐
Is this an institutional pharmacy (hospital pharmacy with outpatient prescription services or nursing facility pharmacy)?	☐	☐	☐
Is this a government-run pharmacy?	☐	☐	☐

If the pharmacy is enrolling as a result of a change in ownership, please indicate the previous name and previously assigned provider number of that facility.

_____ _____
Pharmacy Name Previously Assigned Medicaid Number

Physician-employed Practitioners

_____ _____
Collaborating/Employing/Supervising Physician's Name Alabama Medicaid Provider Number

Independent Rural Health Clinics Only: (Check all that apply)	Yes	No
Family Planning	☐	☐
Prenatal	☐	☐
EPSDT (**Must** complete EPSDT Agreement)	☐	☐

SECTION II – UNIQUE STATUS INFORMATION

Do you want to be enrolled as:	Yes	No
An EPSDT Screening Provider? (**Must** complete EPSDT agreement)	☐	☐
A Plan First Provider? (**Must** complete the Plan First Enrollment form and Agreement)	☐	☐

SECTION III – REQUIRED ATTACHMENTS:

Providers listed below must submit additional attachments:

All Licensed Providers	Must attach a copy of current licensure.
All Providers of Lab Services	Must attach a copy of CLIA certificate or certificate of waiver with approved specialty services.
Ambulatory Surgical Centers (ASC)	Must attach a copy of Medicare certification, copy of current hospital transfer agreement to a hospital that accepts Alabama Medicaid patients, evidence that all physicians utilizing the ASC will accept Alabama Medicaid patients, and a copy of state license.
Ambulance Companies	Must attach a copy of the permit/license from DPH and Medicare Certification letter.
Certified Registered Nurse Practitioners	Must attach a copy of current nurse's license, current CRNP license, and copy of certification from the American Nurses Credentialing Center.
Clinical Lab Providers	Must attach a copy of CLIA certificate with approved specialty services as appropriate, a copy of state license, and a copy of Medicare certification.
Dentists/Oral Surgeon	All dentists performing IV sedation must attach a copy of the IV sedation certification issued by the Board of Dental Examiners of Alabama to be reimbursed for these services. All dentists enrolling as an Oral Surgeon must provider a copy of the Oral Surgery Certification.
FQHC Providers Only	Must attach a list of contracted providers, names and addresses of satellite centers that have been approved by the Public Health Service, and a copy of grant award. Enrollment is only for the period of the grant award. It must be renewed annually.
Hospitals	Must provide a copy of state license, copy of Joint Accreditation, Medicare Certification letter, and Utilization Review Plan. State license and Joint Accreditation are not required for a change in ownership.
Independent Nurse Practitioners	Copy of the certified registered nurse practitioner protocol signed by a collaborating physician.
Independent Radiology Facilities	Must provide a copy of Medicare certification and a copy of Alabama Department of Public Health Certificate of X-ray inspection.
Mammography Services	Must attach a copy of certification of mammography systems from the FDA.
Nurse Midwives	Must provide a copy of their American College of Nurse Midwife certificate, current enrollment in the American College of Nurse Midwife Continuing Competency Assessment Program, copy of certified nurse midwife protocol signed by a collaborating physician, and a letter from the hospital granting admitting privileges for deliveries.
Occupational Therapists	Must attach a copy of the certificate from the American Occupational Therapy Association.
Pharmacies	Must attach a copy of Business License and State Board of Pharmacy Permit and DEA Certificate. Must attach a copy of valid license for supervising registered pharmacist.
Physical Therapists	Must attach a copy of the individual's graduation certificate and proof of current licensure.
Physiological Lab Providers	Must provide a copy of Medicare certification and state license.
Rural Health Clinics	Must provide a copy of Medicare certification. (Independent Rural Health Clinics **must** include an Encounter Rate Letter)

SECTION IV – DISCLOSURE INFORMATION

Complete EITHER Section IV or Section V

This section must be filled out by individuals enrolling as providers.

List all contractual relationships with medical entities and the provider numbers of those entities:
(Attach additional sheets if necessary.)

_____
_____
_____
_____

If provider and payee are not the same, describe the business and financial relationship between the two.

_____

Have you ever been excluded, debarred, suspended or sanctioned from any state or federal program?
☐ Yes ☐ No
If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license: (attach additional sheets if necessary)

_____
_____
_____
_____

Is your license currently suspended or restricted? ☐ Yes ☐ No
If yes, please fully explain the details including dates, the state where the incident occurred and any adverse action against your license: (attach additional sheets if necessary)

_____
_____
_____
_____

Have you ever been convicted of a crime? (excluding minor traffic citations) ☐ Yes ☐ No

Convicted means that:

1) A judgement of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:
   a) There is a post trial motion or appeal, or
   b) The judgement of conviction or other record related to the criminal conduct has been expunged or otherwise removed;
2) A Federal, State or local court has made a finding of guilt against an individual or entity;
3) A Federal, State or local court has accepted a plea of guilty or *nolo contendere* by an individual or entity; or
4) An individual or entity has entered into participation in a first offender, deferred adjudication, or other program or arrangement where judgement of conviction has been withheld.

If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license:

_____
_____
_____
_____

Do you have any outstanding criminal fines, restitution orders, or overpayments identified in this state or any other state? ☐ Yes ☐ No

SECTION V – DISCLOSURE INFORMATION

Complete EITHER Section IV or Section V

Providers who operate as a corporation, organization, institution, agency, partnership, professional association, or similar entity must complete the following information for each of the following individuals: (Make additional copies as necessary)

Owners	Officers
Agents	Directors
Managing Employees	Shareholders with 5% or more controlling interest

This form must be completed for anyone who holds one of the above listed positions.

The completion of this section is required to establish a new group or payee.

Name:	Title:
Home Address:	Business Address:
Social Security Number:	Employer's Tax ID:
Driver's License Number & Issuer:	Driver's License Expiration Date:
Date of Birth:	Sex: ☐ Male ☐ Female
Previous Home Address:	Previous Business Address:

If provider and payee are not the same, describe the business and financial relationship between the two.

_____
_____
_____

List all contractual relationships with medical entities and the provider numbers of those entities: (attach additional sheets if necessary)

_____
_____
_____

Are you related as spouse, parent, child, or sibling to any other owner, officer, agent, managing employee, director or shareholder? ☐ Yes ☐ No If yes, please give names and relationships (Attach additional pages if necessary):

Name	Relationship

DISCLOSURE INFORMATION – Cont.

Have you ever been excluded, debarred, or sanctioned from any state or federal program? ☐ Yes ☐ No
If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license: (attach additional sheets if necessary)

_____

_____

_____

Is your license currently suspended or restricted? ☐ Yes ☐ No

If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license: (attach additional sheets if necessary)

_____

_____

_____

Have you ever been convicted of a crime? (excluding minor traffic citations) ☐ Yes ☐ No

Convicted means that:

1. A judgement of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:
   a) There is a post-trial motion or appeal pending, or
   b) The judgement of conviction or other record related to the criminal conduct has been expunged or otherwise removed;
2. A Federal, State or local court has made a finding of guilt against an individual or entity;
3. A Federal, State or local court has accepted a plea of guilty or *nolo contendere* by an individual or entity; or
4. An individual or entity has entered into participation in a first offender, deferred adjudication, or other program or arrangement where judgement of conviction has been withheld.

If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license:

_____

_____

_____

_____

Do you have any outstanding criminal fines, restitution orders, or overpayments identified in this state or any other state? ☐ Yes ☐ No

SECTION VI - SIGNATURE

Must be signed with an original signature

To the best of my knowledge, the information supplied on this document is accurate and complete and is hereby released to EDS and the Alabama Medicaid Agency for the purpose of issuing a Medicaid provider number.

I hereby authorize, consent to, and request the release to the Alabama Medicaid Agency of any and all records concerning me, including, but not limited to, employment records, government records, and professional licensing records, and any other information requested by the Alabama Medicaid Agency for purposes of acting on my application to be an enrolled provider under the Alabama Medicaid program.

Signature of applicant (or an authorized representative if you are enrolling as a provider group/supplier)

_____

Signature

_____ _____

Title Date

Out of State Providers:

Indicate date(s) of service From: _____ To:_____

Do Not Write In This Area

(For Office Use Only)

_____

Date**:**_____

Initials: _____

QC Date: _____

QC Initials_____

SECTION VI - SIGNATURE (Continue)

Penalties for Falsifying information on the Medicaid Health Care Provider / Supplier Enrollment Application

1. 18 U.S.C. § 1001 authorizes criminal penalties against an individual who in any matter within jurisdiction of any depart or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious of fraudulent statement or entry.

   Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000. 18 U.S.C. § 3571 Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against an individual who "knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a program under a Federal health care program.

   The offender is subject to fines of up to $25,000 and/or imprisonment for up to five years.

3. The Civil False Claims Act, 31 U.S.C. § 3729 imposes civil liability, in part, on any person who:

   a) knowingly presents, or causes to be presented, to an officer or an employee of the United States Government a false or fraudulent claim for payment or approval;
   b) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or
   c) conspire to defraud the Government by getting a false or fraudulent claim allowed or paid.

4. Section 1128B(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency…

   A claim…that the Secretary determines is for a medical or other item or service that the person knows or should know:

   a) was not provided as claimed; and/or
   b) the claim is false or fraudulent.

   This provision authorizes a civil monetary penalty of up to $10,000 per each item or service, an assessment of up to 3 times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.

5. The Government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment." **Remedies include compensatory and punitive damages, restitution and recovery of the amount of the unjust profit.**

PROVIDER AGREEMENT

**Name of Provider _____ *Medicaid Provider ID _____

**(Doing Business As) _____ **Medicare Provider ID _____

**Service Site_____ **Mailing Address _____

_____ _____

*Please list additional provider numbers on the Addendum Statement for this Agreement. New applicants should leave this space blank.

As a condition for participation as a provider under the Alabama Medicaid Program (MEDICAID), the provider (Provider) agrees to comply with all terms and conditions of this Agreement.

I. ALL PROVIDERS

1.1 Agreement and Documents Constituting Agreement.

A copy of the current *Alabama Medicaid Provider Manual* and the *Alabama Medicaid Administrative Code* has been or will be furnished to the Provider. This Agreement is deemed to include the applicable provisions of the State Plan, *Alabama Medicaid Administrative Code*, and *Alabama Medicaid Provider Manual*, as amended, and all State and Federal laws and regulations. If this Agreement is deemed to be in violation of any of said provisions, then this Agreement is deemed amended so as to comply therewith. Invalidity of any portion of this Agreement shall not affect the validity, effectiveness, or enforceability of any other provision. Provider agrees to comply with all of the requirements of the above authorities governing or regulating MEDICAID. Provider is responsible for ensuring that employees or agents acting on behalf of the Provider comply with all of the requirements of the above authorities.

1.2 State and Federal Regulatory Requirements.

1.2.1 Provider has not been excluded or debarred from participation in any program under Title XVIII (Medicare) or any program under Title XIX (Medicaid) under any of the provisions of Section 1128(A) or (B) of the Social Security Act (42 U.S.C. § 1320a-7), or Executive Order 12549. Provider also has not been excluded or debarred from participation in any other state or federal health-care program. Provider must notify MEDICAID or its agent within ten (10) business days of the time it receives notice that any action is being taken against Provider or any person defined under the provisions of Section 1128(A) or (B), which could result in exclusion from the Medicaid program

1.2.2 Provider agrees to disclose information on ownership and control, information related to business transactions, and information on persons convicted of crimes in accordance with 42 C.F.R. Part 455, Subpart B, and provide such information on request to MEDICAID, the Alabama Attorney General's Medicaid Fraud Control Unit, and/or the United States Department of Health and Human Services. Provider agrees to keep its application for participation in the Medicaid program current by informing MEDICAID or its agent in writing of any changes to the information contained in its application, including, but not limited to, changes in ownership or control, federal tax identification number, or provider business addresses, at least thirty (30) business days prior to making such changes. Provider also agrees to notify MEDICAID or its agent within ten (10) business days of any restriction placed on or suspension of the Provider's license or certificate to provide medical services, and Provider must provide to MEDICAID complete information related to any such suspension or restriction.

1.2.3 This Agreement is subject to all state and federal laws and regulations relating to fraud and abuse in health care and the Medicaid program. As required by 42 C.F.R. §431.107, Provider agrees to keep any and all records necessary to disclose the extent of services provided by the Provider to individuals in the Medicaid program and any information relating to payments claimed by the Provider for furnishing Medicaid services. Provider also agrees to provide, on request, access to records required to be maintained under 42 C.F.R. §431.107 and copies of those records free of charge to MEDICAID, its agent, the Alabama Attorney General's Medicaid Fraud Control Unit, and/or the United States Department of Health and Human Services. All such records shall be maintained for a period of at least three years plus the current year. However, if audit, litigation, or other action by or on behalf of the State of Alabama or the Federal Government has begun but is not completed at the end of the above time period, or if audit findings, litigation, or other action has not been resolved at the end of the above time period, said records shall be retained until resolution and finality thereof.

1.2.4 The Alabama Attorney General's Medicaid Fraud Control Unit, Alabama Medicaid Investigators, and internal and external auditors for the state/federal government and/or MEDICAID may conduct interviews of Provider employees, subcontractors and its employees, witnesses, and recipients without the Provider's representative or Provider's legal counsel present unless the person voluntarily requests that the representative be present. Provider's employees, subcontractors and its employees, witnesses, and recipients must not be coerced by Provider or Provider's representative to accept representation by the Provider, and Provider agrees that no retaliation will occur to a person who denies the Provider's offer of representation. Nothing in this agreement limits a person's right to counsel of his or her choice. Requests for interviews are to be complied with, in the form and the manner requested. Provider will ensure by contract or other means that its employees and subcontractors over whom the Provider has control cooperate fully in any investigation conducted by the Alabama Attorney General's Medicaid Fraud Control Unit and/or MEDICAID. Subcontractors are those persons or entities who provide medical goods or services for which the Provider bills the Medicaid program or who provide billing, administrative, or management services in connection with Medicaid-covered services.

1.2.5 Provider must not exclude or deny aid, care, service or other benefits available under MEDICAID or in any other way discriminate against a person because of that person's race, color, national origin, gender, age, disability, political or religious affiliation or belief. Provider must provide services to Medicaid recipients in the same manner, by the same methods, and at the same level and quality as provided to the general public.

1.2.6 Provider agrees to comply with all state and federal laws relating to the preparation and filing of cost reports, audit requirements, and inspection and monitoring of facilities, quality, utilization, and records.

1.2.7 Under no circumstances shall any commitments by MEDICAID constitute a debt of the State of Alabama as prohibited by Article XI, Section 213, Constitution of Alabama of 1901, as amended by Amendment 26. It is further agreed that if any provision of this Agreement shall contravene any statute or Constitutional provision or amendment, whether now in effect or which may, during the course of the Agreement, be enacted, then that conflicting provision in the Agreement shall be deemed null and void. The Provider’s sole remedy for the settlement of any and all disputes arising under the terms of this Agreement shall be limited to the filing of a claim against Medicaid with the Board of Adjustment for the State of Alabama.

1.2.8 In the event litigation is had concerning any part of this Agreement, whether initiated by Provider or MEDICAID, it is agreed that such litigation shall be had and conducted in either the Circuit Court of Montgomery County, Alabama, or the United States District Court for the Middle District of Alabama, Northern Division, according to the jurisdiction of those respective courts. This provision is not intended to, nor shall it operate to, enlarge the jurisdiction of either of said courts, but is merely an agreement and stipulation as to venue.

1.3 Claims and Encounter Data

1.3.1 Provider agrees to submit claims for payment in accordance with billing guidelines and procedures promulgated by MEDICAID, including electronic claims. Provider certifies that information submitted regarding claims or encounter data will be true, accurate, complete, and that such information can be verified by source documents from which data entry is made by the Provider. Further, Provider understands that any falsification or concealment of a material fact may be prosecuted under state and/or federal laws.

1.3.2 Provider must submit encounter data required by MEDICAID or any managed care organization to document services provided, even if the Provider is paid under a capitated fee arrangement.

1.3.3 All claims or encounters submitted by Provider must be for services actually rendered by Provider. Physician providers must submit claims for services rendered by another in accordance with MEDICAID rules regarding providers practicing under physician supervision. Claims must be submitted in the manner and in the form set forth in the *Alabama Medicaid Provider Manual*, and within the time limits established by MEDICAID for submission of claims. Claims for payment or encounter data submitted by the provider to a managed care entity or MEDICAID are governed by the Provider's contract with the managed care entity. Provider understands and agrees that MEDICAID is not liable or responsible for payment for any Medicaid-covered services provided under the managed care Provider contract, or any agreement other than this Medicaid Provider Agreement.

1.3.4 Federal and state law prohibits Provider from charging a recipient or any financially responsible relative or representative of the recipient for Medicaid-covered services, except where a copayment is authorized under the Medicaid State Plan. (42 C.F.R. §447.20). The provider (or its staff) must advise each recipient when MEDICAID payment will not be accepted prior to services being rendered, and the recipient must be notified of responsibility for the bill. The fact that Medicaid payment will not be accepted must be recorded in the recipient's medical record.

1.3.5 As a condition for eligibility for Medicaid benefits, a recipient assigns all rights to recover from any third party or any other source of payment to MEDICAID (42 C.F.R. §433.145 and §22-6-6.1, Code of Alabama 1975). Except as provided by MEDICAID's third-party recovery rules *(Alabama Medicaid Administrative Code*, Chapter 20), Provider agrees to accept the amounts paid under MEDICAID as payment in full for all covered services. (42 C.F.R. §447.15).

1.3.6 Provider must refund to MEDICAID any overpayments, duplicate payments, and erroneous payments which are paid to Provider by MEDICAID as soon as the payment error is discovered.

1.3.7 Provider has an affirmative duty to verify that claims and encounters are received by MEDICAID or its agent and implement an effective method to track submitted claims against payments made by MEDICAID.

1.3.8 MEDICAID'S obligation to make payments hereunder is subject to the availability of State and Federal funds appropriated for MEDICAID purposes. Further, MEDICAID'S obligation to make payments hereunder is and shall be governed by all applicable State and Federal laws and regulations. In no event shall the MEDICAID payment exceed the amount charged to the general public for the same service.

1.3.9 Provider shall not charge MEDICAID for services rendered on a no-cost basis to the general public.

1.3.10 Provider is prohibited from offering incentives (such as discounts, rebates, refunds, or other similar unearned gratuity or gratuities) other than an improvement(s) in the quality of service(s), for the purpose of soliciting the patronage of MEDICAID recipients. Should the Provider give a discount or rebate to the general public, a like amount shall be adjusted to the credit of MEDICAID on the MEDICAID claim form, or such other method as MEDICAID may prescribe. Failure to make a voluntary adjustment by the Provider shall authorize MEDICAID to recover same by then existing administrative recoupment procedures or legal proceedings.

1.3.11 Provider agrees and hereby acknowledges that payments made under this agreement are subject to review, audit adjustment and recoupment action. In the event that Provider acquires or has acquired ownership of another MEDICAID provider through transfer, sale, assignment, merger, replacement or any other method, whether or not a new Agreement is required, Provider shall be responsible for any unrecovered improper MEDICAID payments made to the previous provider. An indemnification agreement between Provider and the previous provider shall not affect MEDICAID'S right to recovery.

1.3.12 Provider agrees to comply with the provisions of the *Alabama Medicaid Provider Manual* regarding the transmission and receipt of electronic claims and eligibility verification data. Provider must verify that all claims submitted to MEDICAID or its agent are received and accepted. Provider is responsible for tracking claims transmissions against claims payments and detection and correcting all claims errors. If Provider contracts with third parties to provide claims and/or eligibility verification data from MEDICAID, the Provider remains responsible for verifying and validating all transactions and claims, and ensuring that the third party adheres to all client data confidentiality requirements.

II. RECIPIENT RIGHTS

2.1. Provider must maintain the recipient's state and federal right of privacy and confidentiality to the medical and personal information contained in Provider's records.

2.2. The recipient must have the right to choose providers unless that right has been restricted by MEDICAID or by waiver of this requirement from CMS. The recipient's acceptance of any service must be voluntary.

2.2.1 The recipient must have the right to choose any qualified provider of family planning services.

III. ADVANCE DIRECTIVES - HOSPITAL, HOME HEALTH, HOSPICE, AND NURSING HOME PROVIDERS

3.1 The provider shall comply with the requirements of §1902(w) of the Social Security Act (42 USC §1396a(w)) as described below:

3.1.1 Maintain written policies and procedures in respect to all adult individuals receiving medical care by or through the provider about patient rights under applicable state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;

3.1.2 Provide written information to all adult individuals on patient policies concerning implementation of such rights;

3.1.3 Document in the patient's medical record whether or not the individual has executed an advance directive;

3.1.4 Not condition the provision of care or otherwise discriminate against a patient based on whether or not he/she has executed an advance directive;

3.1.5 Ensure compliance with requirements of state law (whether statutory or recognized by the courts) concerning advance directives;

3.1.6 Provide (individually or with others) for education for staff and the community on issues concerning advance directives; and

3.1.7 Furnish the written information described above to adult individuals as required by law.

IV. TERM, AMENDMENT, AND TERMINATION

This Agreement will be effective from the date all enrollment documentation has been received and verified until the date the Agreement is terminated by either party. This Agreement may be amended as required, provided such amendment is in writing and signed by both parties concerned. Either party may terminate this Agreement by providing the other party with fifteen (15) days written notice. MEDICAID may immediately terminate the Agreement for cause if the Provider is excluded from the Medicare or Medicaid programs for any reason, loses its licenses or certificates, becomes ineligible for participation in the Medicaid program, fails to comply with the provisions of this Agreement, or if the Provider is or may be placing the health and safety of recipients at risk. MEDICAID may terminate this Agreement without notice if the Provider has not provided services to Medicaid recipients in excess of five (5) claims or $100.00 during the last fiscal year.

Provider Signature _____
(Must be an original signature)

Date _____

Name and Title of Person signing for Provider **(Please print)**

_____

This Agreement must be completed for enrollment purposes. All five pages of the agreement are to be returned with this application. Below is a guide to completing page 1 of the Provider Agreement.

COMPLETION TIPS

- **Information submitted on page 1 of the Provider Agreement, should match that which is indicated in Section I – General Information.**
- **Name of Provider – Indicate the name of the individual or facility you are enrolling using this application.**
- **(Doing Business As) – Indicate the name of the payee as shown in Section I – General Information.**
- **Service Site – Indicate the physical location as shown in Section I – General Information.**
- **Medicare Provider I D – Indicate the Medicare number as shown in Section I – General Information.**
- **Mailing Address – Indicate address to which general mail-outs should be sent. General mail-outs does not include EOPs or paper checks.**

Alabama Medicaid Provider Enrollment

Additional Enrollment Forms

Corporate Board of Directors Resolution
W-9 Taxpayer Identification Number Request
Medicaid Audit Information
Electronic Funds Transfer Authorization Agreement
Electronic Explanation of Payment (EOP) Agreement
Plan First
EPSDT Agreement
Statement of Compliance (2 copies)
Physiological Laboratory Certification

CORPORATE BOARD OF DIRECTORS RESOLUTION

Required for corporations only and **must** be an original, notarized form

For physician groups that operate as corporations, this form must only be filled out once and submitted with the application for the group/payee number.

State of _____

County of _____

On The _____ Day Of _____ , _____ At A Meeting Of The Board

of Directors of _____, A Corporation, Held in The City Of

_____ , In _____ County, With a Quorum Of The Directors

City Of _____, In _____ County, With A Quorum Of The Directors Present, The Following Business Was Conducted:

It Was Duly Moved And Seconded That The Following Resolution Be Adopted:
Be It Resolved That The Board Of Directors Of The Above Corporation Does Hereby Authorize

_____

And His/Her Successors In Office To Negotiate, On Terms And Conditions That He/She May Deem Advisable, A Contract Or Contracts With The Alabama Medicaid Agency, And To Execute Said Contract Or Contracts On Behalf Of The Corporation, And Further We Do Hereby Give Him/Her The Power And Authority To Do All Things Necessary To Implement, Maintain, Amend, Or Renew Said Contract.

The Above Resolution Was Passed By A Majority Of Those Present And Voting In Accordance With The By-Laws And Articles Of Incorporation.

I Certify That The Above Constitutes A True And Correct Copy Of A Part Of The Minutes Of A Meeting Of The Board Of Directors Of _____

Held On The _____ Day of _____, _____

_____
Signature Of Secretary of Board

Subscribed And Sworn Before Me, _____, A Notary Public For The

County Of _____, On The _____ Day Of _____, _____.

Notary Stamp or Seal (**If stamp or seal does not visibly contain the expiration date of commission, the date must be indicated in the next block.**)	Notary Public, County Of _____ State Of _____ Expiration Date Of Commission: _____, _____

W-9

(Obtain TIN for payments other than interest, dividends, or Form 1099-B gross proceeds)

Taxpayer Identification Number Request

Please complete the following information. We are required by law to obtain information from you when making a reportable payment to you. If you do not provide us with this information, your payments may be subject to 31 percent federal income tax backup withholding. Also, if you do not provide us with this information, you may be subject to a $50 penalty imposed by the Internal Revenue Service under section 6723.

Federal law on backup withholding preempts any state or local law remedies, such as any right to a mechanic's lien. If you do not furnish a valid TIN, or if you are subject to backup withholding, the payor is required to withhold 31 percent of its payment to you. Backup withholding is not a failure to pay you. It is an advance tax payment. You should report all backup withholding as a credit for taxes paid on your federal income tax return.

Instructions:

Complete Part 1 by completing the row of boxes that corresponds to your tax status. Complete Part 2 if you are exempt from Form 1099 reporting. Complete Part 3 to sign and date the form.

Part 1 Tax Status: (complete one row of boxes)

Individuals:	Individual Name:	Individual's Social Security Number (SSN): ___ ___ ___ - ___ ___ - ___ ___ ___ ___

A sole proprietorship may have a 'doing business as' trade name, but the legal name is the name of the business owner.

Sole Proprietor:	Business Owner's Name:	Business Owner's SSN or Employer ID Number: ___ ___ ___ ___ ___ ___ ___ ___ ___	Business or Trade Name

Partnership:	Name of Partnership:	Partnership's Employer ID Number: ___ ___ - ___ ___ ___ ___ ___ ___ ___	Partnership's Name on IRS records (see IRS mailing label)

A corporation may use an abbreviated name or its initials, but its legal name is the name on the articles of incorporation.

Corporation, exempt charity, or other entity:	Name of Corporation or Entity:	Employer Identification Number: ___ ___ - ___ ___ ___ ___ ___ ___ ___

Part 2 Exemption:

If exempt from Form 1099 reporting, check here: ☐
and circle your qualifying exemption reason below

1. Corporation, except there is no exemption for medical and healthcare payments or payments for legal services.
2. Tax Exempt Charity under 501(a), or IRA
3. The United States or any of its agencies or instrumentalities
4. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions.
5. A foreign government or any of its political subdivisions.

Part 3 Signature:

Person completing this form: _____

Signature: _____

Date: _____

Phone: (_____) _____

MEDICAID AUDIT INFORMATION

This form is required for:

- Hospitals
- Hospital-affiliated ambulatory surgical centers
- Freestanding psychiatric facilities
- Alabama Department of Mental Health and Retardation
- Nursing facilities
- Home health agencies
- Renal dialysis facilities
- Intermediate Care Facilities/Mentally Retarded (ICF/MR), 15 beds or less

Cost reports, for applicable providers, are to be filed according to Medicare regulations. Please provide us with the following information.

Medicaid Provider No. _____
(To be filled out by EDS)

Provider Name: _____

Current Fiscal Year End: _____

Medicare Intermediary: _____
(Name and address of
where you send your _____
Medicare cost report)

_____

Phone:_____

Contact For Cost Report
Information: Name: _____
(At facility)

Phone: _____

Number of Beds: Medicaid _____Medicare _____ Acute Care _____

Long Term Care _____Total Beds for the facility _____

Nursing Homes: Indicate facility class: _____
(A) Nursing facility without a Medicare number
(B) Nursing facility with a Medicare number
(H) Unclassified

Out-of-state facilities: Do you participate in your state's Medicaid program? ☐ Yes ☐ No
Is this facility chain affiliated? ☐ Yes ☐ No

ELECTRONIC FUNDS TRANSFER (EFT) INFORMATION

Electronic Funds Transfer (EFT) is the **required** payment method to deposit funds for claims approved for payment. These funds can be credited to either checking or savings accounts, directly into a provider's bank account, *provided* the bank selected accepts Automated Clearing House (ACH) transactions. EFT also avoids the risks associated with mailing and handling paper checks, **ensuring funds are directly deposited into a specified account.**

The following items are specific to EFT:

- The release of direct deposits depends on the availability of funds. EFT funds are released as directed by the Alabama Medicaid Agency. The earliest date funds are available is Thursday mornings following the checkwrite (Friday in the event of a Monday State holiday).

- Pre-notification to your bank takes place following the application processing. The pre-notification process takes place over a time frame of twenty-one (21) days. Direct deposits when owed to a provider will be made according to the release guidelines in the bullet above. The Explanation of Payment (EOP) Report furnishes the details of individual payments made to the provider's account during the weekly cycle.

- The availability of EOP reports is unaffected by EFT and they typically are received by the end of the week following the checkwrite.

EDS must provide the following notification according to ACH guidelines:

> "Most receiving depository financial institutions receive credit entries on the day before the effective date, and these funds are routinely made available to their depositors as of the opening of business on the effective date.
>
> However, due to geographic factors, some receiving depository financial institutions do not receive their credit entries until the morning of the effective day and the internal records of these financial institutions will not be updated. As a result, tellers, bookkeepers, or automated teller machines (ATM) may not be aware of the deposit and the customer's withdrawal request may be refused. When this occurs, the customer or company should discuss the situation with the ACH coordinator of their institution who, in turn, should work out the best way to serve their customer's needs."
>
> The effective date for EFT under the Alabama Medicaid Program is based on release of funds as directed by the Alabama Medicaid Agency. The earliest effective date is Thursday following the checkwrite (if funds were made available from the Agency for the particular provider).

Complete the attached Electronic Funds Transfer Authorization Agreement. **A voided check or an official letter from the bank must be returned with the agreement to EDS.**

ELECTRONIC FUNDS TRANSFER AUTHORIZATION AGREEMENT

Note: Complete all sections below and **attach a voided check or an official letter from the bank for verification purposes.**
Enter ONE group/payee provider number per form. EFT information is an enrollment requirement.

Type of Authorization _____New _____Change

Provider Name	Group/Payee Provider No.
Payee Address	**Provider Phone No.**

Bank Name	ABA/Transit No.
Bank Phone No.	**Account No.**
Bank Address	**Type Account (check one)**
	Checking ☐
	Savings ☐

I (we) hereby authorize Alabama Medicaid Agency to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I (we) am responsible for the validity of the information on this form. If the company erroneously deposits funds into my (our) account, I (we) authorize the company to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay period.

I (we) agree to comply with all certification requirements of the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by the Alabama Medicaid Agency or its fiscal agent. I (we) understand that payment claims will be from federal and state funds, and that any falsification, or concealment of material fact, may be prosecuted under federal and state laws.

I (we) will continue to maintain the confidentiality of records and other information relating to recipients in accordance with applicable state and federal laws, rules, and regulations.

_____ _____
Authorized Signature **(Original signature required)** Date

_____ _____
Title Internet Address (if applicable)

_____ _____
Contact Name Phone

Input By_____ Date _____

ELECTRONIC EXPLANATION OF PAYMENT (EOP) AGREEMENT

GROUP/BILLING PROVIDER NUMBER: _____

GROUP/BILLING NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CONTACT: _____ PHONE NUMBER: _____

SUBMITTER ID: _____

VENDOR NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

VENDOR PHONE NUMBER: _____

VENDOR CONTACT: _____

I (we) request to receive Electronic Explanation of Payment (EOP) information and authorize the information to be deposited in our electronic mailbox. I (we) accept financial responsibility for costs associated with receipt of Electronic EOP information.

I (we) understand that paper-formatted EOP information will continue to be sent to my (our) mailing address as maintained at EDS until I (we) submit an Electronic EOP Certification Request Form.

I (we) will continue to maintain the confidentiality of records and other information relating to recipients in accordance with applicable state and federal laws, rules, and regulations.

Authorized Signature: _____ Date: _____

Title: _____ Internet Address: _____

FOR EDS USE ONLY

BILLING MODE: _____ EOP MODE: _____ PROTOCOL: _____

CONTACT DATE: _____ SOFTWARE MAILED: _____

TEST DATE: _____ AGREEMENT DATE: _____ APPROVAL DATE: _____

BEGIN DATE: _____ END DATE: _____

NOTES: _____

_____

_____

PLAN FIRST AGREEMENT / ENROLLMENT FORM

The completion of the attached form is necessary to ensure the provider's understanding of the acceptance of program requirements including, but not limited to the oral contraceptive distribution system.

Please complete all required blanks and sign where indicated. If you are enrolled for a clinic, please indicate based on the following instructions:

1. I _____ - indicate the physician or clinic name.
2. **Executed - indicate the date you sign the contract.**
3. Signature - should be signed by the physician. If a clinic provider, the person responsible for clinic administration (e.g. chief of staff, business office manager, etc.) should sign.
4. Title - indicate whether this is the physician or the relationship of the signee to the clinic.

Enrollment

1. Please indicate this information, as it appears on the EDS file including your physical address.
2. The provider number is the number of the physician or clinic.
3. Contact - please indicate who should be called when questions about the program arise.

The completed form should be returned to:

EDS Provider Enrollment
Attn: Enrollment
P.O. Box 244035
Montgomery, AL 36124

AGREEMENT FOR PARTICIPATION IN THE PLAN FIRST PROGRAM

I _____ hereby enter into an agreement with the Alabama Medicaid Agency for participation in the Plan First.

I agree to provide services as described in the family Planning, Plan First Application of the Alabama Medicaid Provider Manual and in accordance with the terms and conditions expressed in the Medicaid State Plan for Medical Assistance, the Administrative Code, the approved 1115 Research and Demonstration Waiver and all other federal and state laws and regulations as they pertain to my performance under this agreement. I understand that these requirements are incorporated by reference into this agreement. I understand that I am bound to follow all specifications, terms and conditions expressed in these manuals and documents, and that my failure to do so may result in termination of this agreement and recoupment of any or all funds paid under this agreement.

I further agree that oral contraceptives provided to recipients enrolled in Plan First will be dispensed directly to them. Therefore, this agreement also serves as an agreement with the Alabama Department of Public Health (ADPH) to receive oral contraceptives at no cost. On behalf of myself and any and all practitioners associated with this medical office, group practice, health department, community/migrant/rural clinic, or other entity of which I am acting "physician-in-chief" or equivalent, I agree to the following:

1. ADPH supplied oral contraceptives will be dispensed only to women age 19-44 who are Medicaid Plan First participants. No more than a 12-month supply (13 packs) will be provided at one time.
2. I will comply with the ADPH's requirements for ordering oral contraceptives.
3. I understand the ADPH retains the right to validate and account for the oral contraceptives.

Executed this _____ day of _____, 200___.

_____
Signature

_____ _____
Title Typed / Printed Name

Enrollment Information

Name: _____

Address (including street address and county) _____

City _____ Zip:_____ Provider #:_____

Office Phone: _____ FAX#: _____

Type of Enrollment: _____Group _____ Individual

Group or Clinic Name:_____

Group/Payee Number : _____ Contact Name: _____

FOR EDS USE ONLY

Date Accepted: _____ By: _____ Indicator Added: _____

EPSDT AGREEMENT

I, the undersigned, agree to carry out the key components of a thorough medical well-child examination. The examination/screen must, at a minimum, include:

- a comprehensive health and developmental history (including assessment of both physical and mental health development),
- a comprehensive **unclothed** physical exam,
- appropriate immunizations according to age and health history,
- laboratory tests (including blood lead level assessment appropriate for age and risk factors),
- health education (including anticipatory guidance), and
- treatment and/or referral, if indicated.

In addition, I understand that the performance of these services must be documented, as all medical records pertaining to the EPSDT Program are subject to audit by federal and state agency representatives. Also, I agree to follow up on all referred cases and to document whether or not the initial referral visit was kept by the recipient.

_____
Provider's Printed Name

_____
Provider's Signature
(Original signature required)

Do you wish to be listed in the EPSDT published list? ☐ Yes ☐ No

Note: This form is not applicable to providers who wish to add the EPSDT specialty to an existing provider number.

The Alabama Medicaid Agency does not enroll providers in the VFC Program. To enroll in the VFC Program, contact the Alabama Department of Public Health, Immunization Division at (800) 469-4599.

STATEMENT OF COMPLIANCE

Assurance is hereby given that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), the Age Discrimination Act of 1975 (42 U.S.C. 6101, et seq.), the Americans with Disabilities Act of 1990, and the Regulations issued thereunder by the Department of Health and Human Services (45 CFR Parts 80, 84, and 90) no individual shall, on the ground of race, sex, color, creed, national origin, age, or handicap be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or services by this institution.

_____

Signature **(Original signature required)**

_____

Typed or Printed Provider's Name

_____

Date

Agency Copy (Return with application)

CR FORM-2

STATEMENT OF COMPLIANCE

Assurance is hereby given that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), the Age Discrimination Act of 1975 (42 U.S.C. 6101, et seq.), the Americans with Disabilities Act of 1990, and the Regulations issued thereunder by the Department of Health and Human Services (45 CFR Parts 80, 84, and 90) no individual shall, on the ground of race, sex, color, creed, national origin, age, or handicap be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or services by this institution.

_____

Signature **(Original signature required)**

_____

Typed or Printed Provider's Name

_____

Date

Provider Copy

(This item should be retained in the Provider's office and must be posted in facility.)

CR FORM-2

PHYSIOLOGICAL LABORATORY CERTIFICATION

I, _____, hereby acknowledge that I agree to
(Print or type Physician's name)
provide general physician supervision in the areas of ultrasounds, Doppler services, and noninvasive peripheral vascular studies to :

_____
(Name of physiological laboratory)

These responsibilities include, but may not be limited to, verifying periodically that the equipment is functioning properly and producing the quality of results expected. I also assume responsibility for following on a continuing basis those technicians doing ultrasound, Doppler testing, and peripheral vascular studies, and assisting them with any problems that may occur when providing these services. I will give direction and make recommendations to management regarding proper training or follow-up training.

_____ _____
Physician's Signature Date
(Original signature required)

_____
Address

_____

_____
Telephone Number

Alabama Medicaid Provider Enrollment

Reference Materials

Check list of Required Forms
Frequently Asked Questions (FAQs)
Frequently Used Terms
Contact Information
Alabama Medicaid Participation Requirements
Table of County Codes **(in-state and bordering states)**

APPLICATION CHECK LIST

Did You Remember to …

Complete and enclose the following <u>required</u> forms?

- ❒ Type and Specialty Sheet
- ❒ Completed Section I – General Information
- ❒ Section IV or V Disclosure Information***
- ❒ Section VI – Signature Page
- ❒ Alabama Medicaid Agency Provider Agreement
- ❒ Alabama Medicaid Provider Enrollment Application
- ❒ IRS W-9 Form
- ❒ Corporate Board of Directors Resolution*
- ❒ Certificate of Incorporation/Certificate of Authority (see below)**
- ❒ Statement of (Civil Rights) Compliance Form
- ❒ Electronic Funds Transfer Authorization Agreement

* *Corporate Board of Directors Resolution*: Required for corporations only and **must** be notarized.

** *Certification of Incorporation/Certificate of Authority*: This certificate is located in your corporation records or can be obtained from the Office of the Secretary of State. If your corporation is registered in a state other than Alabama, a Certificate of Authority to do business in Alabama is required. Send a copy of this document when you return the enrollment application.

*** *Section IV Disclosure Information* is required if enrolling an individual. *Section V – Disclosure Information* is required if enrolling a facility or group/payee. Section V – Disclosure Information must be completed for each person who fills a position listed in the heading of the form.

Enclose the following attachments, if applicable?

- ❒ Copy of License
- ❒ Copy of CLIA Certificate
- ❒ Copy of Certification of Mammography Systems for all providers rendering mammography services
- ❒ Copy of IV Sedation/GA permit – dental providers only
- ❒ Medicaid Audit Information – facilities only
- ❒ EPSDT Agreement, if applicable.
- ❒ Encounter Rate Letter - independent rural health clinics only

Refer to Section III for additional information regarding attachments.

Include <u>original</u> signatures on the following documents?

- ❒ Alabama Medicaid Agency Provider Agreement
- ❒ Alabama Medicaid Provider Enrollment Application
- ❒ Corporate Board of Directors Resolution*
- ❒ Electronic Funds Transfer Authorization Agreement
- ❒ Electronic Explanation of Payment (EOP) Agreement
- ❒ EPSDT Agreement
- ❒ Statement of Compliance (2 copies)
- ❒ Physiological Laboratory Certification

Please retain a copy of all documents for your records

FREQUENTLY ASKED QUESTIONS

Q. How long does it take to process an enrollment application?
A. EDS should complete the enrollment process with ten (10) working days of receipt of a correctly completed application. Omissions, absence of required forms and incomplete applications are returned. To avoid delays please ensure all applications are complete with the required forms and attachments.

Q. Can I fax my applications for processing?
A. No. Applications must contain original, not copied signatures.

Q. Should I send my application via express or certified mail?
A**.** Because of the tremendous amount of incoming mail, sending applications through express or certified mail helps to ensure receipt of the information. This also serves as your proof of submission and enables us to locate information through tracking numbers and guarantee quicker delivery.

Q. Since I am a new provider, what provider number should I enter on this application?
A. Leave the provider number blank. EDS will enter the provider number for new providers.

Q. How will I be notified of my new provider number?
A. EDS prints a notification letter the day the application is approved, denied, or returned. The letter is mailed to the physical address listed on the application. Approval letters contain the new provider number. Within a few weeks of issuing a new provider number, EDS mails a provider manual and other necessary documents.

Q. Should I hold claims until I receive a provider number?
A. Yes.

Q. As a Medicaid provider, how long am I required to retain records pertaining to services rendered?
A**.** Detailed records should be retained for a period of three (3) years plus the current year. Refer to the *Alabama Medicaid Administrative Code*, Rule 560-X-1-.21.

FREQUENTLY USED TERMS

Term	Usage
Individual	An individual practitioner of the healing arts who is licensed, certified, or otherwise authorized to perform a specific medical service or provide medical care, equipment, and/or supplies in the normal course of business. This individual may be a solo practitioner or a part of a group. Examples of individuals are physicians and dentists. An individual provider must complete an enrollment application for each physical location in which he or she practices.
Group/Payee	An entity composed of one or more individuals, generally created to provide coverage of patient's needs in terms of office hours, professional backup and support, or range of services, resulting in specific billing or payment arrangements. It is possible that the group itself is not licensed or certified, but the individual(s) who compose the group are licensed, certified, or otherwise authorized to provide heath care services. An individual can be a member of multiple groups. Examples of groups are: • Two physicians practicing as a group where they bill and receive payment for their services as a group. • An incorporated individual billing and receiving payment as a corporation. The group must fill out an application. Each individual participating in the group may have to complete an application. Refer to Alabama Medicaid Participation Requirements.
Facility/Organization	An entity, other than an individual, that is licensed, certified, or otherwise authorized to provide medical services, care, equipment, or supplies in the normal course of business. The licensure, certification, or other recognition is granted to the organization entity. Individual owners, managers, or employees of the organization may also be certified, licensed, or otherwise recognized as individual providers in their own right. Examples of organizations are hospitals, laboratories, ambulance companies, and pharmacies.
Change Of Ownership (CHOW)	Under procedures set forth by the Centers for Medicare and Medicaid Services (CMS) and Alabama Medicaid Agency, a change in ownership of a facility does not terminate Medicare eligibility, therefore, Medicaid participation may be continued provided that the new owners comply with the following requirements: • Obtain re-certification as a Title XVIII (Medicare) facility under the new ownership, if applicable. • Complete new Medicaid provider enrollment packet for each provider number affected by the Change of Ownership. • Provide Medicaid with copy of the Contract of Sale (specifically, a signed agreement that includes the identification of previous and current owners).
Electronic Claims Submission	Please be advised that signing the provider agreement automatically enrolls providers for Electronic Claims Submission of Medicaid claims only. For more information regarding ECS, please contact EDS at 1-800-456-1242.

CONTACT INFORMATION

Written Communication

Pharmacy, Dental, and UB-92 Claims	EDS P.O. Box 244032 Montgomery, AL 36124-4032
CMS-1500	EDS P.O. Box 244032 Montgomery, AL 36124-4032
Inquiries, Provider Enrollment Information, Provider Relations, and diskettes for Electronic Claims Submission (ECS)	**EDS** **P.O. Box 241685** **Montgomery, AL 36124-1685**
Medicare-Related Claims	EDS P.O. Box 244032 Montgomery, AL 36124-4032
Prior Authorization (includes Medical Records)	EDS P.O. Box 244032 Montgomery, AL 36124-4032
Adjustments/Refunds	EDS P.O. Box 241684 Montgomery, AL 36124-1684

Telephone Communication

Automated Voice Response System (AVRS)	(800) 727-7848
Provider Assistance Center	(800) 688-7989
Provider Enrollment	(888) 223-3630
Provider Relations Representatives	(800) 688-7989
Electronic Media Claims (EMC) Help Desk	(800) 456-1242
EDS Operator	(334) 215-0111

ALABAMA MEDICAID PARTICIPATION REQUIREMENTS

The following chart indicates participation requirements by program. Refer to this chart to ensure you meet the minimum participation requirements to participate in the Alabama Medicaid Program.

Provider Type	***Participation Requirements***
Ambulance	• Must submit a copy of Medicare Title XVIII certification. • Must maintain and submit a disclosure of the extent and cost of services, equipment, and supplies furnished to eligible recipients. • Must submit a copy of license or permit in the state of Alabama or the state in which services are provided.
Ambulatory Surgical Center	• Must submit a copy of Medicare Title XVIII certification. • Possess and submit licensure from the appropriate licensing authorities. • Possess and submit a copy of a transfer agreement with an acute care facility (refer to the *Alabama Medicaid Agency Administrative Code* rule no. 560-X-38-.05 for details). • Be certified by the Division of Provider Services of the Alabama Department of Public Health as meeting specific statutory requirements and the Conditions of Participation.
Audiologist	• Must submit copy of current license from the state of Alabama or the state in which services are provided. • Self-employed audiologists must also possess and submit a Certificate of Accreditation for their facility.
Chiropractor	• Must submit a current certification and/or be licensed to practice and operate within the scope of practice established by the Board of Chiropractic Examiners or board in state in which services will be provided. • Must submit a copy of Medicare Title XVIII certification. • Chiropractors are enrolled only for services provided to QMB recipients or to recipients referred as a result of an EPSDT screening.
CORF	• Enrolled only for services provided to QMB eligible recipients (crossover claims).
Dentistry (General)	• Must submit copy of current license from the state of Alabama or the state in which services are provided. • EDS assigns a provider number for each office location. • Dentists who perform IV sedation services must submit a copy of their IV certification to EDS with their provider enrollment application. • Must submit a copy of DEA certification.
Durable Medical Equipment	• The provider's business must have a physical location in the state of Alabama or within a 30-mile radius of the Alabama state line. The business must be in a location that is zoned for business. This requirement does not apply to Medicare crossover providers. • There must be at least one person present to conduct business at the physical location. Answering machines and/or answering services are not acceptable as personal coverage during normal business hours (8:00 a.m. – 5:00 p.m.) The provider may serve all counties adjoining the county in which he has a business license and is physically located. Satellite businesses affiliated with a provider are not covered under the provider agreement; therefore, no reimbursement will be made to a provider doing business at a satellite location. • Medicaid will enroll manufacturers of augmentative/alternative communication devices (ACDs) regardless of location. • The provider shall have no felony convictions and no record of willful or grossly negligent noncompliance with Medicaid or Medicare regulations. • Must submit copy of current business license. • Providers must notify EDS in writing of any changes to the information contained in its application at least 30 business days prior to making such changes. These changes may include, but are not limited to, changes in ownership or control, federal tax identification number, or business address changes.

Provider Type	Participation Requirements
FQHC	• Submit appropriate documentation from the Department of Health Resources and Services, Public Health Services (PHS), that the center meets FQHC requirements as evidenced by a copy of a grant awards letter. • Submit a budgeted cost report for its initial cost reporting period • Federally Funded Health Centers, which are Medicare certified, must also submit copies of Medicare certification. • Comply with the Clinical Laboratory Improvement Amendments of 1988 (CLIA) for all laboratory-testing sites. • Provider contracts are valid for the time of the grant award period, and are renewed yearly in accordance with the grant renewal by PHS. A copy of the grant renewal by PHS must be forwarded to EDS as verification of continuing FQHC status. They are renewed upon receipt of proof that requirements stated in the Alabama Medicaid Agency Administrative Code Rule No. 560-X-48-01 are met. • Each satellite center must complete an enrollment application. Physicians, Nurse Practitioners, Nurse Midwives, and Physician Assistants associated with the clinic must also complete enrollment applications. • Be certified to participate as a Medicare provider.
Hearing Services	• Hearing Aid dealers must posses and submit a valid license issued by the Alabama Board of Hearing Aid Dealers, or as issued by the state in which the business is located.
Home Health	• Be certified to participate as a Medicare provider. • Be certified by the Division of Provider Services of the Alabama Department of Public Health as meeting specific statutory requirements and the Conditions of Participation. • Must obtain a certificate of need from SHPDA. • Submit a copy of the agency's most recent cost report. • For continued participation as a Medicaid home health care provider, an annual Medicare cost report for the home health agency's fiscal year must be submitted to Medicaid within 30 calendar days after the report is submitted to Medicare. A copy of any Medicare audit adjustment or settlement must be submitted to Medicaid within 30 calendar days of receipt by the home health agency. • If the cost report is not provided as required, the home health agency's contract may be terminated for noncompliance.
Hospice	• Be certified to participate as a Medicare provider. • Be certified by the Division of Provider Services of the Alabama Department of Public Health as meeting specific statutory requirements and the Conditions of Participation. • Submit a copy of the current hospice license from the Alabama Department of Public Health • Submit a copy of the notification from CMS showing the approved Medicare reimbursement rate. • Submit a copy of the notification from the Alabama Department of Public Health showing the fiscal year end and the Medicare provider number.

Provider Type	*Participation Requirements*
Hospital/Lithotripsy/Swing Beds	• Be certified to participate as a Medicare provider. • Be certified by the Division of Provider Services of the Alabama Department of Public Health as meeting specific statutory requirements and the Conditions of Participation. • Receive certification for participation in the Title XVIII Medicare and Title XIX Medicaid programs as a short term or children's hospital. Hospital types are identified on the Hospital Request for Certification in the Medicare/Medicaid Program (CMS-1514) or its successor. • Possess a license as a hospital by the state of Alabama in accordance with current rules contained in the Rules of Alabama State Board of Health, Bureau of Provider Services, Chapter 420-5-7. • Submit a budget of cost for medical inpatient services for its initial cost reporting period, if a new facility. • Submit a written description of an acceptable utilization review plan currently in effect. • The effective date of enrollment cannot be earlier than the Medicare certification dates. Participating out-of-state (border) hospitals are subject to all program regulations and procedures that apply to participating Alabama hospitals and must submit copies of their annual certification from CMS, State licensing authority, and other changes regarding certification. "Border" is defined as within 30 miles of the Alabama state line. • Nonparticipating hospitals are those hospitals that have not executed an agreement with Alabama Medicaid covering their program participation, but that provide medically necessary covered out-of-state services. • All Medicaid admissions to participating and nonparticipating facilities are subject to program benefits and limitations based on current Medicaid eligibility. **Lithotripsy** • Submit documentation that the lithotripsy machine is FDA approved. • **Post-Hospital Extended Care Services (PEC)** • Must provide nursing care by or under the supervision of a registered nurse on a 24-hour basis. • Provide bed and board in a semi-private room; private accommodations may be used if the patient's condition requires isolation, if the facility has no ward or semi-private rooms, or if all ward or semi-private rooms are full at the time of admission and remain so during the recipient's stay. • Provide medically necessary over-the-counter (non-legend) drug products ordered by physician (Generic brands are required unless brand name is specified in writing by the attending physician). • Must provide personal services and supplies ordinarily furnished by a nursing facility for the comfort and cleanliness of the patient. • Possess nursing and treatment supplies as ordered by the patient's physician or as required for quality nursing care. • Provide services ordinarily furnished to an inpatient of a hospital. **Swing Beds** • Have fewer than 100 beds (excluding newborns and intensive care beds) and be located in a rural area as defined by the Census Bureau based on the most recent census. • Possess certification as a Medicare provider. • Possess certificate of need for swing beds. • Comply with SNF conditions of participation for patient rights, specialized rehabilitation services, dental services, social services, patient activities, and discharge planning. (Most other SNF conditions would be met by virtue of the facilities compliance with comparable conditions of participation for hospitals). • Must not have in effect a 24-hour nursing waiver. • Must not have had a swing bed approval terminated within the two years previous to application for swing bed participation.
Independent Laboratory	• Possess and submit certification as a Medicare provider. • Possess and submit certification as a valid CLIA provider if a clinical lab. • Exist independently of any hospital, clinic, or physician's office. • Possess licensure in the state where located, when it is required by that state or equivalent documentation.

Provider Type	Participation Requirements
Independent Nurse Practitioner	• Must submit copy of current RN license from the state of Alabama or the state in which services are provided • Must submit copy of current CRNP license • Copy of current certification as a Certified Registered Nurse Practitioner in the appropriate area of practice (family, pediatric or neonatal) from a national certifying agency. • Copy of the certified registered nurse practitioner protocol signed by a collaborating physician. • If intending to prescribe medication, must provide proof of prescriptive authority from the licensure board.
Independent Radiology	• Possess and submit certification as a Medicare provider. • Exist independently of any hospital, clinic, or physician's office. • Possess licensure or equivalent documentation in the state where located. • Possess and submit copy of Public Health Certification of X-Ray Inspection. • For mammography services, possess and submit a certification issued by the FDA.
Independent Rural Health Clinic	• Be certified to participate as a Medicare provider. • Be certified by the Division of Provider Services of the Alabama Department of Public Health as meeting specific statutory requirements and the Conditions of Participation. • Submit a copy of the following documentation of Medicare certification: the Centers for Medicare and Medicaid Services (CMS) letter assigning the Medicare Provider number, and submit a budgeted cost report for initial cost reporting period. • Submit a copy of the CMS Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate or waiver. • Must have a CRNP or PA on staff. Submit a copy of license for employed CRNP or PA and proof of prescriptive authority, if applicable. • Operate in accordance with applicable federal, state, and local laws. • The effective date of enrollment is the latter of the following: the first day of the month the enrollment is received or the date of the Medicare certification.
Licensed Social Worker	• Must submit a copy of Medicare Title XVIII certification. • Submit a copy of current certification as a licensed social worker from the Board of Social Work Examiners. • Must submit proof of educational degree.
Nurse Midwife	• Submit a copy of the current licensure or licensure renewal card. • Submit a copy of the American College of Nurse-Midwife certificate. • Submit a copy of the current enrollment in the American College of Nurse Midwives Continuing Competency Assessment Program. • Submit a copy of the Certified Nurse Midwifery Protocol signed by your collaborating physician • Submit a letter from the hospital granting admitting privileges for deliveries.
Nursing Facility	• Possess certification for Medicare Title XVIII. • Be certified by the Division of Provider Services of the Alabama Department of Public Health as meeting specific statutory requirements and the conditions of participation. • Submit a budget to the Provider Reimbursement Section at Medicaid for the purpose of establishing a per diem rate. • Must obtain a Certificate of Need (CON) from SHPDA. • Execute a Provider Agreement and a Nursing Facility/Patient Agreement with Medicaid.
Optical Dispensary Shop	• The provider's business must have a physical location in the state of Alabama or within a 30-mile radius of the Alabama state line. This requirement does not apply to Medicare crossover providers.
Optician	• Must submit current certification and license to practice in the state of Alabama or the state in which services are provided.
Optometrist	• Must submit current certification and license to practice in the state of Alabama or the state in which services are provided. • To prescribe therapeutic agents for the eye the optometrist must be licensed by the Alabama Board of Optometry.
Oral Surgeon	• Must be licensed in the state of Alabama or the state in which services are provided. EDS assigns a provider number for each office location. • Must submit a copy of certification in the field of oral surgery. • Oral Surgeons who perform general anesthesia or IV sedation services must submit a copy of their GA/IV certification to EDS with their provider enrollment application. • Must submit a copy of DEA certification.

Provider Type	Participation Requirements
Pharmacy	• Operate under a permit or license to dispense drugs as issued by the Alabama State Board of Pharmacy or appropriate authority in the State where the service is rendered. • Agree to abide by the rules and regulations of third party billing procedures. Refer to Section 3.3.6, Third Party Liability, for more information. • Maintain records, including prescriptions, to fully disclose the extent of services rendered. Pharmacies should maintain records, such as purchase invoices and recipient signature logs, within the state of Alabama. At a minimum, prescription files and invoices must be available for examination. • Must submit copy of valid license for registered pharmacist. **Out-of-State Pharmacies** • Out-of-state bordering pharmacies, located within 30 miles of the border of the state of Alabama, may be enrolled as a regular Medicaid pharmacy provider. Out-of-state pharmacies not bordering Alabama, or located more than 30 miles from the state border, will be enrolled on a temporary basis for emergency situations. • Possess certification from the State Board of Pharmacy in the state where the pharmacy is registered and hold a permit to operate in the state of residence. • Complete an application for out-of-state pharmacies. • Agree to abide by the Alabama state provider tax law. • Alabama Medicaid program limitations apply to both out-of-state and in-state pharmacies. Medicaid uses the same payment methodology to reimburse out-of-state and in-state pharmacies enrolled with the Alabama Medicaid Program for drugs dispensed. • Must submit copy of valid license for registered pharmacist.
Physician	• Must submit copy of current license from the state of Alabama or the state in which services are provided. • EDS will not enroll physicians having limited licenses unless complete information as to the limitations and reasons are submitted in writing to the Provider Enrollment Unit for review and consideration for enrollment. • Should submit a copy of DEA certification. • If performing EPSDT screenings, must submit an EPSDT Agreement and current CLIA certification. • If performing Mammography procedures, must submit a copy of the Mammography certification issued by FDA. • If administering vaccinations, provider must contact ADPH – Vaccines for Children (VFC) Program at (800) 469-4599 for enrollment. • To have secondary claims processed, provider should submit a copy of the Medicare certification. **Medicare certification is NOT required for enrollment.** Out-of-state no-bordering physicians, meaning physicians outside of the 30-mile radius from the state line of Alabama, should not submit the Medicare certification at any time.
Physician-Employed Anesthesiology Assistants (AA)	• Must submit a copy of Medicare Title XVIII certification. • Must submit copy of current license from the state of Alabama or the state in which services are provided. • Must submit copy of current certification with the Alabama Board of Medical Examiners Certificate of Registration and National Commission for Certification of Anesthesiologist Assistants.
Physician Employed Physician Assistant (PA)	• Must submit copy of current license from the state of Alabama or the state in which services are provided. • If intending to prescribe medication, must provide proof of prescriptive authority from the licensure board.
Physician-Employed Certified Registered Nurse Anesthetist (CRNA)	• Must submit copy of current RN license from the state of Alabama or the state in which services are provided. • Must submit copy of current CRNA license • Must submit copy of certification with the Alabama Board of Medical Examiners Certificate of Registration.
Physician-Employed Certified Registered Nurse Practitioner (CRNP)	• Must submit copy of current RN license from the state of Alabama or the state in which services are provided • Must submit a copy of current CRNP license • Must submit a copy of certification from the American Nurses Credentialing Center.
Physiological Lab	• Possess and submit certification as a Medicare provider. • Possess a Physician's Supervisory Certification and utilize certified technicians for ultrasounds, Doppler services, and non-invasive peripheral vascular studies if a physiological labs. • Possess licensure or equivalent documentation in the state where located.

Provider Type	Participation Requirements
Podiatrist	• Must submit a current certification and/or be licensed to practice and operate within the scope of practice established by the Alabama Board of Podiatry or board in state in which services will be provided. • Podiatrists are enrolled only for services provided to QMB recipients or to recipients referred as a result of an EPSDT screening.
Preventive Health Education	• Providers include clinics or other organizations that use licensed practitioners of the healing arts within the scope of practice under state law and federal regulations. Professional instructors of the provider must meet the following qualifications (according to specialty) as listed below: • A health educator must have graduated from an accredited four-year college or university with major course work in public health, health education, community health, or health/physical education/recreation with a concentration in health. • A social worker must be licensed by the Alabama Board of Social Work Examiners. • A registered nurse must be licensed by the Alabama Board of Nursing as a Registered Nurse. • A nurse practitioner must have successfully completed a supplemental program in an area of specialization, and must be licensed by the Alabama Board of Nursing as a Registered Nurse and be issued a certificate of approval to practice as a Certified Registered Nurse Practitioner in the area of specialization. • A nurse midwife must be licensed by the Alabama Board of Nursing as a Registered Nurse and a Certified Nurse Midwife. • A nutritionist must be licensed as a Registered Dietitian by the American Dietetic Association. • A nutritionist associate must have graduated from a four-year college or university with major course work in nutrition or dietetics. • A professional counselor must be licensed by the Alabama Board of Examiners in Counseling. • A health instructor must have a bachelor's degree with extensive experience in providing instruction in preventive health education supplemented by a training program approved by the Alabama Medicaid Agency.
Private Duty Nursing	• Private Duty Nursing providers are enrolled to recipients referred as a result of an EPSDT screening. These providers must submit a copy of current Alabama business license and letter requesting to become a private duty nursing provider. Only in-state private duty nursing providers and out-of-state providers within 30 miles of the state line qualify for participation in the Medicaid program.
Provider-based Rural Health Clinic	• Be certified to participate as a Medicare provider. • Be certified by the Division of Provider Services of the Alabama Department of Public Health as meeting specific statutory requirements and the Conditions of Participation • Submit a copy of the Centers for Medicare and Medicaid Services (CMS) letter assigning the Medicare Provider number as documentation of Medicare certification. • Submit a copy of the CLIA certificate to waiver. • Must have a CRNP or PA on staff. Submit a copy of license for employed CRNP or PA and proof of prescriptive authority, if applicable. • Submit a budgeted cost report for initial cost reporting period. • The effective date of enrollment is the date of Medicare certification. Providers, who request enrollment more than 120 days after Medicare certification, are enrolled on the first day of the month the enrollment is approved.
Psychiatric Hospital	• Be certified to participate as a Medicare provider. • Be certified by the Division of Provider Services of the Alabama Department of Public Health as meeting specific statutory requirements and the Conditions of Participation. • Receive certification for participation in the Medicare/Medicaid program. • Possess a license as an Alabama psychiatric hospital in accordance with current rules contained in the Alabama Administrative Code. State hospitals that do not require licensing as per state law are exempt from this provision. • Be accredited by the Joint Commission on Accreditation of Hospitals. • Have a distinct unit for children and adolescents. • Have a separate treatment program for children and adolescents. • Submit a written description of an acceptable utilization review plan currently in effect. • Submit a budget of cost for medical inpatient services for its initial cost reporting period, if a new provider.

Provider Type	*Participation Requirements*
Psychology	• Possess and submit a doctoral degree from an accredited school or department of Psychology. • Must submit a current certification and/or be licensed to practice and operate within the scope of practice established by the Alabama Board of Psychology or board in state in which services will be provided. • Psychologists are enrolled only for services provided to QMB recipients or to recipients referred as a result of an EPSDT screening.
Renal Dialysis Facility	• Be certified to participate as a Medicare provider. • Be certified by the Division of Provider Services of the Alabama Department of Public Health as meeting specific statutory requirements and the Conditions of Participation. • Certification for participation in the Title XVIII Medicare Program. • Approval by the appropriate licensing authority.
Therapy	• A qualified Speech Therapist must have a Certification of Clinical Competence in Speech Language Pathology or be eligible for certification and licensed by the Alabama Board of Examiners for Speech, Language Pathology, and Audiology. (Submit copy) • A qualified OT must be registered by the American Occupational Therapy Certification Board and licensed by the Alabama State Board of Occupational Therapy. (Submit copy) • A qualified PT must be a graduate of a program of physical therapy approved by the Council on Medical Education of the American Medical Association and the American Physical Therapy Association or its equivalent. A qualified PT must be licensed by the Alabama Board of Physical Therapy. (Submit copy) • Therapists are enrolled only for services provided to QMB recipients or to recipients referred as a result of an EPSDT screening.

ALABAMA MEDICAID COUNTY CODES

This table provides county codes and rural/urban indicator codes for Alabama counties and surrounding states. The first two digits indicate the county code. The third digit indicates whether the county is considered Urban (1) or Rural (2). Enter the appropriate county code in the County Code fields on Page 1 of the Alabama Medicaid Provider Enrollment Application.

Code	*County*	*Code*	*County*	*Code*	*County*
01/1	Autauga	25/2	Dekalb	49/1	Mobile
02/1	Baldwin	26/1	Elmore	50/2	Monroe
03/2	Barbour	27/2	Escambia	51/1	Montgomery
04/2	Bibb	28/1	Etowah	52/1	Morgan
05/1	Blount	29/2	Fayette	53/2	Perry
06/2	Bullock	30/2	Franklin	54/2	Pickens
07/2	Butler	31/2	Geneva	55/2	Pike
08/1	Calhoun	32/2	Greene	56/2	Randolph
09/2	Chambers	33/2	Hale	57/1	Russell
10/2	Cherokee	34/2	Henry	58/1	St. Clair
11/2	Chilton	35/1	Houston	59/1	Shelby
12/2	Choctaw	36/2	Jackson	60/2	Sumter
13/2	Clarke	37/1	Jefferson	61/2	Talladega
14/2	Clay	38/2	Lamar	62/2	Tallapoosa
15/2	Cleburne	39/1	Lauderdale	63/1	Tuscaloosa
16/2	Coffee	40/1	Lawrence	64/2	Walker
17/1	Colbert	41/2	Lee	65/2	Washington
18/2	Conecuh	42/1	Limestone	66/2	Wilcox
19/2	Coosa	43/2	Lowndes	67/2	Winston
20/2	Covington	44/2	Macon	***OUT OF STATE***	
21/2	Crenshaw	45/1	Madison	95/1	Florida
22/2	Cullman	46/2	Marengo	96/1	Georgia
23/1	Dale	47/2	Marion	97/1	Mississippi
24/2	Dallas	48/2	Marshall	98/1	Tennessee
				99/1	All others